

Mr. Chairman and Members of the Committee, my name is Tom Mikkelsen. I would like to thank you for the opportunity to present testimony today. I will be presenting from the perspective of several roles I currently serve in the Metro East St. Louis area. I am board certified in Family Practice and a Fellow of the American Academy of Family Physicians. My assignment as Commander (Chief Executive Officer), Scott Medical Center at Scott AFB brought me to for my fourth Illinois assignment prior to retiring from the United States Air Force. I currently serve as the COO & Vice President for Medical Affairs at Touchette Regional Hospital which is a safety net hospital and behavioral facility serving the East St. Louis area. Touchette is affiliated with the Southern Illinois Healthcare Foundation (SIHF). The Foundation is a community-based Federally Qualified Health Center (FQHC) Network, comprised of nearly 40 health centers serving eight counties from the East St. Louis area to Effingham to Olney. We have 160 physicians who provide services in Family Practice, Obstetrics/Gynecology, Internal Medicine, Pediatrics, Dental, and Behavioral Health to 101,103 patients. We serve approximately 5,000 individuals who are dual eligible enrollees, and the clinics provide nearly 10,000 pediatric referrals to the children's hospitals in St. Louis, annually. In 2010, the Foundation was designated as a satellite office for the Illinois Health Information Exchange Regional Extension Center (IL-HITREC) and is actively working with 41 counties in southern Illinois to implement EHRs. Southern Illinois Healthcare Foundation has a shared arrangement to provide administrative and executive director services for Lincoln Land HIE and for the Illinois Health Exchange Partners (ILHEP) a private health information network serving Southern Illinois where I currently serve as the Chair of the Board of Members for the HIE. The founders of ILHEP include the Southern Illinois Healthcare Foundation, the Southern Illinois Health Care Association, which is a 250 physician Independent Practice Association, Anderson

Hospital in Maryville, and Hospital Sisters Health Services with four hospitals in Southern Illinois. We undertook a similar process as the Lincoln Land HIE and have operating agreements that outline participant privacy and security responsibilities.

I want to address four key areas in my remarks today: technical limitations on sequestering sensitive data for transmission through an HIE, limits on disclosure of sensitive data and the impact on patient safety for emergency treatment and on coordination of care between multiple physicians in the care team, implications of meaningful choice and clinic workflows, and coordination of care with out-of-state healthcare providers.

As the committee is aware, Illinois has broader “sensitive” PHI disclosure restrictions that go beyond the federal HIPAA restrictions including information about drug and alcohol abuse and treatment, mental health and developmental disabilities, HIV, AIDS and sexually transmitted disease, genetic testing, child abuse or neglect and sexual assault or abuse. There are unanticipated and potentially significant patient safety issues related to partial information edited to meet exclusions, which I will discuss in a moment. There are also technology limitations to the ability of HIEs and electronic health records to mask sensitive PHI that may be in a CCD documents, test results, discharge summaries or some other dictation. Text data from a dictated History and Physical note could contain a reference to a drug and alcohol or mental health treatment history and medications. It’s not uncommon to have a dictated note read something like this: “This is Tom Mikkelson dictating a history and physical on Smith, John A, date of birth March 3, 1961, and medical record number 12345. The patient is a 51 year old, Caucasian male, a patient of Dr. William Brown, with a past medical history of alcohol dependence and bipolar depression. The patient presented in the ED on July 17 at 9 a.m. complaining of severe abdominal pain,” etc. This information would potentially be part of a discharge summary or

CCD document sent to a Dr. Brown with the patient's written authorization for coordinated care. Because the documents would be delivered in an electronically encrypted envelop to the patient's physician the HIE would not have the ability to parse the data. Nor is it possible to mask or edit the description in such a way that only part of the dictated note would be sent electronically. Consequently, please understand that patient authorization for the electronic communications of clinical information is an all or nothing proposition with today's technology limitations. If the state of Illinois grants patients the legal ability to sequester certain elements of their record in the electronic environment, the committee needs to be aware that we will potentially not be able to send any information for that patient in an electronic manner and will be required to return to manual methods.

There are unanticipated patient safety issues relating to partial information that has been edited to meet exclusions. For example, not knowing all of the medications a patient is taking for behavioral health or HIV can create significant drug-to-drug interactions, some of which can be life threatening and may exacerbate conditions if not carefully balanced, particularly in the clinically vulnerable elderly, developmentally disabled, or mentally ill populations. Incomplete information adds to the treatment risk for physicians and the potential legal risk for both physicians and the transmitters of information due to incomplete patient histories edited diagnoses and medication lists. Our FQHC physicians provide care for community-residing individuals dual eligible beneficiaries with developmental disabilities across southern Illinois. Many of these patients have multiple co-morbidities including behavioral exacerbations and neurological problems such as seizures. They are on multiple medications, and because of that, the incidence of drug-to-drug interactions rises exponentially. This type of patient requires a unique multi-disciplinary approach with a minimum of two (usually remote) specialists and a

local primary care physician who need to carefully coordinate and titrate medications. For example, too much anti-seizure medication or a drug drug interaction may cause behavior-related adverse events putting the patient, group home staff, and other group home residents at risk for physical injury; too little, and seizures are not controlled. When data about medications and their impact on behavior is unavailable to treating physicians, we risk causing harm to these patients and the individuals around them. If we begin editing out medications and diagnoses it also defeats one of the important meaningful use changes of the recent federal legislation to improve patient medication safety via the electronic methods of checking for drug drug interactions. Unfortunately, it also continues to promote the stigmatization of behavioral health and other conditions.

To the issue of meaningful choice and clinic workflows, as an FQHC with over 100,000 lives, we have been working to expand capacity and coordinate care for the additional patients we expect under the Affordable Care Act. It is a workflow challenge for our physicians to have “meaningful choice” conversation with every patient. In the rural areas of Southern Illinois, physician practices are in various phases of implementation of electronic health records systems and may receive clinical data directly interfaced to the EHR, receive data through a secure website and then print and scan reports into the EHR or place them in a paper chart, or received clinical information through fax or mail. To keep our physicians and mid-level practitioners practicing at the tops of their licenses instead of having to explain the different ways in which patient data may be received or sent, authorization for electronic information exchange should continue be managed in the usual manner for consent in the local practice and hospital, regardless of how clinical information is sent and received, if we are to be able to provide timely and appropriate care and protect patient safety and confidentiality. I believe a statewide

campaign promoting the advantages of having health information available when and where it is needed would be helpful. Information currently transmitted or received for treatment, payment and operations (TPO) should be emulated in the HIE realm. Further, although patients may be given rights to see data in those systems retaining patient specific data, any changes should be made through normal means at the source documents not through the HIEs. This would prevent the potential of sources being unaware of potentially important legal changes to health documents.

Finally, the Southern Illinois Healthcare Foundation clinics refer over 10,000 patients annually to hospitals and specialists in St. Louis. I mention this again because it is important for the members of the committee to understand the sheer volume of paper-based clinical information exchange that is already happening today between Illinois and Missouri healthcare providers but through less efficient means. ILHEP will offer a robust electronic referrals and transitions of care product to hospitals and specialists with whom we partner allowing us to establishing closed loop communications and “virtual care teams” to reduce and eventually eliminate the manual referrals processes in place today. Illinois should align its laws to preserve the ability of healthcare providers and other covered entities to continue sharing complete information through the federal HIPAA treatment, payment, and operations provisions without placing an unachievable burden on physicians and hospitals that exchange clinical information securely through electronic means.

In summary, we want the members of the Committee to understand that 1) patient safety considerations must be paramount in determining what data to sequester; 2) there are technical limitations to data granularity today; 3) patient consent management must remain at the level where the patient has the relationship with the healthcare provider who can explain the potential

health implications of not sharing certain information and can determine based upon clinical judgment what will protect the patient's health or safety; and 4) the need to preserve the ability of physicians, hospitals, and other healthcare providers to leverage secure health information exchange technologies in a way that will allow us to achieve the goals of the Triple Aim for better health, improving care, and a lower per capita cost in the new accountable care environment.